Depression Screening and Treatment
An Integrated Primary Care Model

Urban Health Plan, Inc.
Presented by:
Debbie Lester, LMSW
Natasha Borrero, MPH
Our History

- Founded in 1974 by Dr. Richard Izquierdo
- Federal Qualified Health Center (FQHC) designation in 1999
- Accredited by the Joint Commission.
- 4 Sites:
  - El Nuevo San Juan Health Center—1065 Southern Blvd, Bronx, NY
  - Bella Vista Health Center—890 Hunts Point Ave, Bronx, NY
  - Plaza del Castillo Health Center—1515 Southern Blvd, Bronx, NY
  - Plaza del Sol Health Center—37-16 108th St, Corona, NY
- 5 School-Based Sites; 2 Off-Sites 2 Administrative Sites
- 2009: 37,000 Users and 197,000 Encounters
- 82% Hispanic; 15% African-American; 3% Other
- Largest employer in zip code 10459
Our Mission

Urban Health Plan’s (UHP) mission is to continuously improve the health status of underserved communities by providing affordable, comprehensive, and high quality primary and specialty medical care and by assuring the performance and advancement of innovative best practices.

With over 30 years of service and a deeply rooted foundation in the South Bronx, Urban Health Plan is dedicated to rendering care in a culturally proficient, barrier free, individualized, and family oriented manner, with an emphasis on prevention through education and the provision of state-of-the-art services.
Psychological Distress (due mostly to depression)

- **Hunts Point/Mott Haven**: 9%
- **New York City**: 6%

Depression Care:
Pre-collaborative Structure

- No proactive screening for depression
- Minimal Collaboration between Behavioral Health and Primary Care
- Over capacity in Behavioral Health
- Long waits for patients needing external behavioral health services
- No tracking of patient depression outcomes
Total Adult Patients Seen For Primary Care

Total Patients Seen for Primary Care

Jan 08  Feb 08  Mar 08  Apr 08  May 08  Jun 08  Jul 08  Aug 08  Sep 08  Oct 08  Nov 08  Dec 08  Jan 09  Feb 09  Mar 09  Apr 09  May 09  Jun 09  Jul 09  Aug 09  Sep 09  Oct 09  Nov 09  Dec 09  Jan 10  Feb 10  Mar 10  Apr 10  May 10  Jun 10  Jul 10  Aug 10  Sep 10  Oct 10

24901
Percent of Adult Patients Screened for Depression

Goal > 70%

Percent of Patients Screened for Depression

38.3%

Jan 08 to Jan-10
Total Adult Patients in the Registry

Total Patients in the Registry

- Jan 08 to Dec 10
- Number of patients ranges from 400 to 1400
- Data shows a consistent increase over the years
Total Clinically Significant Depressed (CSD) Adult Patients

Total CSD Patients

Jan 08 - Jan 10

Feb 08 - Feb 10

Mar 08 - Mar 10

Apr 08 - Apr 10

May 08 - May 10

Jun 08 - Jun 10

Jul 08 - Jul 10

Aug 08 - Aug 10

Sep 08 - Sep 10

Oct 08 - Oct 10

Nov 08 - Nov 10

Dec 08 - Dec 10

The graph shows the trend of total clinically significant depressed (CSD) adult patients from January 2008 to January 2010. The number of patients generally increases over time, with a significant rise towards the end of the period, reaching a total of 668 patients in January 2010.
Percent of CSD Adult Patients with a 50% Reduction in PHQ

Goal > 40%

Percent of CSD Patients with a 50% Reduction in PHQ

48.5%
Percent of Adult Patients
Reassessed within the past 2 months

Percent of CSD Patients Reassessed within the past 2 Months
Goal > 70%

24.4%
Percent of Adult Patients Reassessed within the past 6 months

Percent of Patients in the Registry Reassessed within the past 6 Months

Goal > 70%

Jan '08 to Dec '10
Percent of Adult Patients in the Registry with a Self Management Goal

Percent of Patients in the Registry with a Self Management Goal
Goal > 90%

Jan 08 - Dec 10
Total Adult Patients with a Diagnosis of Major Depression or Dysthymia

[Graph showing the number of patients with a diagnosis of major depression or dysthymia from January 2008 to December 2010, with the number of patients declining from a peak of around 1100 in early 2008 to 793 by December 2010.]
Percent of Adult Patients Diagnosed with Major Depression or Dysthymia on Antidepressants

Goal > 70%

Percent of Patients Diagnosed with Major Depression or Dysthymia on Antidepressants

81.5%
How We Got There…

- 2001: Participated in Bureau of Primary Health Care Asthma II Collaborative
- 2003: Trained (5) internal experts (Masterminds) to lead performance improvement teams:
  - Depression Team
  - External Referrals Team
  - Diabetes Team
  - Accounts Payable Team
  - Adolescent Obesity Team
- The team adopted measures based on evidence-based guidelines used by the national depression teams.
- UHP has successfully improved the treatment of depression by applying the Care Model, Model for Improvement (PDSA) and Learning Model to change the process of depression care.
  - To learn more about BPHC health disparities collaboratives: [www.healthdisparities.net](http://www.healthdisparities.net)
Team Members

- Paloma Hernandez, MPH, MS  
  CEO-Senior Leader
- Samuel Deleon, MD  
  CMO-Senior Leader
- Debbie Lester, LMSW  
  Director of IACH- Acting Program Coordinator
- Arthur Berger, Ed.D.  
  Director of Behavioral Health - Acting Program Coordinator
- David Lisojo  
  Registry Coordinator
- Prenda Jimenez  
  Administrative Assistant
- Rachana Chowlera, MD  
  Clinician Champion
- Olga Evdos, MD  
  Psychiatrist- Clinical Support
- Fiordalisa Santiago, LCSW  
  Psychotherapist- Clinical Support
- Bernice Perez  
  Counselor
- Natasha Borrero, MPH  
  Assists with Coordination of Depression Program
- Guadalupe Lopez  
  Case Manager- Plaza Del Castillo
- Jessica Cochrane  
  Case Manager- Bella Vista
- Lorenza Figueroa  
  Case Manager- Plaza Del Sol
- Nidia Buitrago  
  Case Manager- Plaza Del Sol
- Jeanette Denizard  
  Senior Case Manager- Geriatric Clinic
- Jennifer Nuñez  
  Case Manager- Geriatric Clinic
- Flora Bautista  
  Case Manager- Adolescent Clinic
- Doreen Gonzalez  
  Case Manager- Prenatal/Pediatric
- Mildred Casiano, LCSW-R, MPH  
  Director of Social Work (ad hoc)
- Jacqueline Jordan, LMSW  
  Director Project Sunrise/IDC Case manager (ad hoc)
- Lisa Martinez  
  Intake Coordinator (ad hoc)
- Alison Connelly, RPA-C  
  Clinical Systems Administrator (ad hoc)
How we grew as a program...

The Early Stages
- Internal Team mirrors the BPHC Depression Collaborative
- POF-163 patients

The Growing Stages
- Team is supported by the internal PI structure at UHP
- Measures begin to improve and program is spread one provider at a time

The Full Spread
- Measures improvement is sustained
- Spread to all providers and all sites including special populations and new patients
- Outcomes data is monitored through reports from the EMR
Senior Leaders implement an interdisciplinary depression team and provide change package.

Initial Population of Focus: 163 patients

PDSA 1 - Case Manager conducts PHQ-2 & PHQ-9 screenings at point of care, and collaborates with PCP’s and BH Providers.

PDSA-2 - Case managers provide face to face and telephone support and set self management goals

PDSA 3 - Psychiatrist is placed on the Team, trains the PCP’s

These PDSA’s become the basis for patient symptom improvement and “breakthrough results.”

An access database is used to monitor patient outcomes and team is emailed data graphs monthly.
Case Managers stationed in Adult Medicine:

- Review provider schedule & patient charts daily
- Conduct abbreviated screening those without PHQ-2/PHQ-9 in the chart

Color-coded sticker system identified those already screened.

Maintained registry of all collaborative patients for self-management follow-up & PHQ-9 reassessments
<table>
<thead>
<tr>
<th>First two Questions are Abbreviated Screening</th>
<th>Not at all 0</th>
<th>Several Days 1</th>
<th>More than half the days 2</th>
<th>Nearly Every day 3</th>
</tr>
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<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way in the past 2 weeks? If yes, ALERT CSW or Provider Immediately</td>
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<tr>
<td>10. If you are experiencing any of these problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?</td>
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<tr>
<td>11. In the past 2 years, have you felt depressed or sad most days, even if you felt ok sometimes?</td>
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<tr>
<td>[Yes] Yes</td>
<td>[No] No</td>
<td></td>
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</tr>
</tbody>
</table>
Mental Health History Form

Ethnicity: □ Hispanic □ African American □ Caucasian □ Asian □ Pacific Islander □ Other

When was the last time you felt Depressed? _______________________________________________________________________________________

Were you ever on Medication for Depression? □ Yes □ No

Which Medication? _________________________

Are you now on any psychiatric medication? □ Yes □ No

Which Medication? _________________________

Who Prescribed this Medication? _______________________________________________________________________________________________

Where? __________________________________________________ When? __________________________

1. Were you ever hospitalized for Depression or other Psychiatric Problem? □ Yes □ No

2. Are you presently receiving Psychiatric treatment elsewhere? □ Yes □ No

Where? __________________________________________________ When? __________________________

What services do you need help with at this time?:

□ Medical Problems □ Domestic Violence

□ Health Insurance Issues □ Drug or Alcohol Treatment

□ Food □ Other: _________________________

Additional Screening

1. Do you have an unexplained burst of energy? □ Yes □ No

2. Does your mind work overtime? □ Yes □ No

3. Do others tell you that you are talking too fast or constantly interrupting them? □ Yes □ No

4. Do you see things that other people don’t see? □ Yes □ No

5. Do you hear things that other people don’t hear? □ Yes □ No

6. Do you worry often or fell nervous? □ Yes □ No

7. Do you get physical symptoms from being nervous, heart racing, sweating? □ Yes □ No

8. Have you experienced a traumatic event?
   a) After this event, have you had frightening thoughts or reminders to this event? □ Yes □ No
   b) After this event, did you begin to feel more isolated and loose interest in activities and people? □ Yes □ No

9. Do you presently drink beer, alcohol or use drugs not prescribed by a doctor? □ Yes □ No

10. If YES, how many days a week do you drink beer or alcohol? If NO, go to question # 16

11. Have you ever felt the need to cut down on your drinking? □ Yes □ No

12. If you answered yes to the question, answer the following:
   a) Have you use drugs or alcohol in the past? □ Yes □ No
   b) Have you ever been in a drug or alcohol treatment/rehab program? □ Yes □ No

13. How often? ____________________________________________

14. How much? ____________________________________________

15. What do you use? _______________________________________

16. Is there anyone physically or emotionally abusing you? □ Yes □ No

17. Has anyone physically or emotionally abused you in the past? □ Yes □ No
Color-coded sticker system

- The team used these stickers to mark paper charts of patients that had been screened.
- Discreet method of facilitating daily chart reviews.

Yellow Stickers:
- Depression Collaborative Patient

Red Sticker:
- Abbreviated Screening Done
Challenges—Before EHR

- Limited physical space for Case Managers to screen at point of care
- Chart reviews cumbersome with paper charts
  - Limited access to patient information/history
- Monthly registry information essential for self management and PHQ follow-up
- Multiple hand-off points left more room for human error
Growing Stages

- Team builds momentum, sustains outcomes and is given permission to spread
- Development of Decision support tools
  - Depression Treatment Algorithm
  - Provider Assistance & Medication Algorithms
- Team strategically spreads one PCP at a time and continues to sustain good outcomes
Population Of Focus

Adult Provider 2

Adult Provider 3

Adult Provider 4

Adult Provider 5

Adult Provider 6

Prenatal Clinic Provider

Plaza Del Sol Providers

Infectious Disease Clinic Provider

New Patient Intake Screening

Providers

Plaza Del Castillo

Provider

Bella Vista Providers

Geriatric Clinic Providers

Providers

New Patient Intake Screening

Population Of Focus
Adult Depression Treatment Algorithm

Abbreviated Screening
(First 2 Questions on the PHQ-9) Administered

Yes to Question 1 and/or 2
Administer PHQ-9 Form

Score of 0 – 4
No Further intervention

Score of 5-9
- Watchful waiting
- Set self-management Goal
- Evaluate for Dysthmia & RX
  Meds if indicated
- Offer counseling
- Meds may or may not be required for mild depression

Follow-up PCP visit
3-12 weeks

Follow-up PHQ-9
Every 12 – 24 weeks
Until remission

Remission:
3 consecutive PHQ score 0-4 repeat PHQ annually if 5 or above – New episode depression

Yes to Question # 9

Score of 10 or More
- Clinically significant depression
- Complete mental health HX form
- Set self-management goal
- RX Meds
- Recommend TX plan

Follow-up PCP every 4 - 8 weeks for 6 months

Follow-up PHQ-9
Every 4 - 8 weeks
Until remission

No to Question 1 or 2
STOP

Notify LMSW to assess for suicide risk. If LMSW / Psychologist not available Provider to assess

Not acutely Suicidal
Continue to evaluate for Depression Collaborative

Acutely Suicidal
Follow UHP Mental Health Emergency Procedures

Follow-up PHQ-9 Every 4 - 8 weeks Until remission

Depression severity scale
No depression 0-4
Mild depression or Dysthmia 5-9
Moderate depression 10-14
Severe depression 15-27
Inclusion into the collaborative for anti-depressant medication management

Start ↓

Assess for
Psychosis, Bipolarity, Primary Anxiety Disorder, Substance and/or Alcohol (ETOH) Abuse/Dependence

Follow-up Assessment 2-4 weeks

You may also start another anti-depressant but can reserve until after SSRI trial

Start SSRI-Any order:
Celexa, Zoloft, Paxil, Lexapro, Prozac

Start Wellbutrin XL if:
1. Pt. concerns of sexual side effects
2. Pt. with concerns ↑ weight gain
Avoid if:
1. Significant ↑ anxiety present
2. History of active eating disorders
3. Possible ETOH withdrawal Wellbutrin SR form available but more cumbersome to use
4. History of seizures
Start Remeron if:
1. Sleep problems
   a. Watch for ↑ weight gain
   b. Watch for Agranulocytosis

Start Effexor XR if:
1. If there is anxiety and depression
   a. Monitor for ↑ blood pressure
Start Cymbalta if:
1. Also for diabetic neuropathic pain

Note: In 2 weeks assess for compliance and side effects. Also ↑ to lowest effective dose if not already on it. In 4-6 weeks assess dose it could take 4-6 weeks to see benefit of dose.

Start
Note: If prior good response with anti-depressant restart that medication

Note: AT ANY POINT
If psychosocial stressors or patient needs support to develop self-management goals refer to:
1. Case Manager (health education)
2. Psychotherapy
3. Stress Reduction

Note: Continue indefinitely if 3+ MDES (Major Depressive Episodes)

In 2 weeks assess for compliance and side effects. Also ↑ to lowest effective dose if not already on it. In 4-6 weeks assess dose it could take 4-6 weeks to see benefit of dose.

Change meds to another SSRI or another anti-depressant and repeat protocol. Consider referral to Psychiatry if two or more failures.
This is just a sample of medication available of those most commonly used. A Psychiatrist is available to consult on these medications, or others not listed. Contact the Director of Behavioral Health.

<table>
<thead>
<tr>
<th>Dosages Pills are available</th>
<th>Minimum ⇒ Max Dosage</th>
<th>Avg. Effective dosage for Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cymbalta</td>
<td>20, 30, 60</td>
<td>20 - 60</td>
</tr>
<tr>
<td>Prozac</td>
<td>10, 20, 40’s</td>
<td>10 – 80</td>
</tr>
<tr>
<td>Zoloft</td>
<td>25, 50, 100</td>
<td>25 - 200</td>
</tr>
<tr>
<td>Celexa</td>
<td>10, 20, 40</td>
<td>10- 40</td>
</tr>
<tr>
<td>Lexapro</td>
<td>5, 10,20</td>
<td>10- 20</td>
</tr>
<tr>
<td>Wellbutrin XL</td>
<td>150, 300</td>
<td>150 - 450</td>
</tr>
<tr>
<td>Wellbutrin SR</td>
<td>100, 150, 200</td>
<td>150 - 400</td>
</tr>
<tr>
<td>Remeron</td>
<td>15, 30, 45</td>
<td>15 - 45</td>
</tr>
<tr>
<td>Effexor XR</td>
<td>37.5, 75, 150</td>
<td>37.5 - 225</td>
</tr>
<tr>
<td>Effexor</td>
<td>25, 37.5, 50, 75, 100</td>
<td>25 - 375</td>
</tr>
<tr>
<td>Paxil CR</td>
<td>12.5, 25, 37.5</td>
<td>12.5 – 75</td>
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<td>Paxil</td>
<td>10, 20, 30, 40</td>
<td>10 – 50</td>
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**Note:**
Wellbutrin XL = Once Daily Dosing
IR and SR forms no more than 200 mg in only one dose and BID dosing every 8 hours.

If simply depressed you can start with lowest effective dose of SSRI if ↑ Anxiety start with lowest dose available.
Services Offered to Adult Patients with Depression

- Primary Care Management of Depression
- Psychiatry
- Psychotherapy
- Case management including Telephone Case management
- Self Management Goal Setting and Follow up
- Referrals to outside social service and community organizations
- Referrals to Health and Wellness programs conducted at Urban Health Plan
  - Canyon Ranch Institute Life Enhancement Program at Urban Health Plan (CRI-LEP)
  - Chronic Disease Self Management Program based on Stanford University (CDSMP)
Program Coordination is Improved
Case Management remains the key to Coordinated Services
Training and Competency Testing of Case managers is Improved
Staff is expanded to include Social Work Interns and Americorp Workers
Monthly Team Meetings and Case Conferences are held
Lists are generated from the EHR for case managers to follow up on patients due for a depression screening.
PHQ 2 and PHQ 9 (Smart Forms in the Electronic Health Record)
Monthly Data Graphs are generated from the electronic health record
Depression Dashboard is created (Spider Graph)
Depression Care: Post-collaborative Structure

- Proactive screening for Depression: PHQ-2 and PHQ-9
- Patient Outcomes Tracked through Electronic Health Record Reports
- Creation of the Behavioral Health Screening Appointment Process
- Integrated Case management and Care Coordination
- PCP and Behavioral Health Co Management
- Integrated Depression Training Program for Providers and Staff at all levels
PHQ-9 in EHR

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: JESSICA TEST  Date: 08/17/2019

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use ‘X’ to indicate your answer)

<table>
<thead>
<tr>
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Total Score: 16

Interpretation
- Minimal Depression
- Mild Depression
- Moderate Depression
- Moderately severe depression
- Severe Depression

Interpretation of Total Score for Depression Severity
Mental Health History Form in EHR

**Brief Mental Health History Form**

- **Symptom**
  - Were you hospitalized for Depression or other Psychiatric problems?
  - Are you presently receiving Psychiatric treatment elsewhere?
  - Do you have an unexplained burst of increased activity or happiness?
  - Does your mind work overtime?
  - Do others tell you that you are talking too fast or constantly interrupting them?
  - Do you see things that other people don't see?
  - Do you hear voices that other people don't hear?
  - Do you often feel nervous or have panic attacks?
  - Do you get physical symptoms from being nervous, heart racing, sweating?

**Notes**

- **Header**
- **Footer**
- **Browse...**
- **Spell check**
- **Denies All**
- **Clear All**
- **Custom**
Standardizing and Sustaining

- Case Managers are trained using materials in the Depression Program Training Guide
  - Protocols
  - Algorithms
  - Helpful Hints for patient contact
  - How to Create Self Management Goals
- Competency forms are used to ensure proper and adequate training
<table>
<thead>
<tr>
<th>Objective/Procedural Step</th>
<th>Date Observed and Performed</th>
<th>Competency confirmed</th>
<th>Trainer's Initials</th>
</tr>
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<tbody>
<tr>
<td><strong>DEPRESSION SCREENING</strong></td>
<td></td>
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<tr>
<td>Able to locate and complete ‘Depression Screening’ form in the HPI section of EMR</td>
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<tr>
<td>Demonstrates knowledge of the PHQ-2 and PHQ-9 screening protocol</td>
<td></td>
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</tr>
<tr>
<td>Administers all questions on PHQ-2/PHQ-9, Functional Assessment question, and Dysthymia question as written</td>
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</tr>
<tr>
<td>Demonstrates knowledge of crisis intervention protocol use when patient answers “several days, more than half the days, or nearly every day” to question 9 on PHQ-9</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates knowledge of PHQ score results (Not Depressed, Mildly Depressed, Clinically Significantly Depressed) and appropriate next steps based on score</td>
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<td></td>
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<tr>
<td>Demonstrates knowledge of Does Not Qualify (DNQ) definition, how it is documented, and when it is to be used</td>
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<tr>
<td>Able to locate and complete ‘Brief Mental Health History’ form in the HPI section of EMR</td>
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<tr>
<td>Administers all questions on Brief Mental Health History form as written for patients with a PHQ score of 10+</td>
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<tr>
<td>Able to define and provide examples of appropriate self-management goals for patients with a PHQ score of 5+</td>
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<tr>
<td>Capable of providing patients with a PHQ score of 10+ with a behavioral health screening appointment in EMR</td>
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<tr>
<td>Capable of providing patients with verbal referrals to external services, as needed, and provide pt with information accordingly</td>
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<tr>
<td>Able to explain case management/follow-up services provided to patients with a PHQ Score of 10+</td>
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</tbody>
</table>
Depression Case Manager’s Training Guide

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CALLING ALL ASSOCIATES!!

DO YOU WANT TO LEARN:
...About potential risk factors and warning signs of various mental health disorders?
...A 5-step action plan that can help you assess certain types of situations?
...And much more?!

Then, email Rebecca Ajasin to register!!
Enrollment is on a FIRST come, FIRST served basis....
So sign up NOW!!

(Commitment is highly required to complete this 2 day course! Registration is also subject to your supervisor’s approval.)

Location: The Learning Center
Date: August 30 & 31, 2010
Time: 9:00 a.m. - 5:00 p.m.

Lunch will be provided!
Life After the EHR

- Case Managers can easily review Provider schedules and conduct chart reviews.
- Access to patient co-morbidities and other presenting conditions/issues.
- Ability to focus on patients with the highest PHQ scores and those not improving.
- Ability to run congruent lists (example: patients with out of control diabetes who suffer from depression).
- Targeted Care Coordination—Using Data Effectively.
Managing a Program Through Data

DEPRESSION DASHBOARD AUGUST

- ORG - % of Patients Screened for Depression
- PDS - % of CSD Patients with a 50% Reduction in PHQ
- PDS - % of Patients Screened for Depression
- POC - % of CSD Patients with a 50% Reduction in PHQ
- BV - % of CSD Patients with a 50% Reduction in PHQ
- BV - % of Patients Screened for Depression
- ENSJ - Percent of CSD Patients with a 50% Reduction in PHQ
- ORG - % of CSD Patients Reassessed within the past 2 Months
- ORG - % of Patients with a Self Management Goal
- ORG - % of Patients Diagnosed with Depression or Dysthymia on Antidepressants
“Having this position has been enabled me to employ some of the skills that I learned in coping with my own depression. It’s been very rewarding to help people going through similar struggles. Some times they’re skeptical at first because depression causes you to feel that you’re the only person in the world that suffers that way, but my job is to raise awareness and show people that they are not alone.”

Jessica Cochrane, Case Manager

“It is important to consider the mind and body while treating the patient. Screening and management of depression is an important part of the medical evaluation. It allows us to identify behavioral health issues and tailor treatment for improved health outcomes. The support of the team, particularly the case manager, is essential to maintaining an effective program.”

Dr. Rachana Chowlera, Physician Champion
2005: Developed **The Institute for the Advancement of Community Health (IACH)** to oversee and support all performance improvement team work.

Mission of the IACH: **To improve the health status of underserved communities by developing and disseminating innovative best practices.**

Implemented the Mastermind Training Program and Performance Improvement Training Curriculum.
UHP Teams

- **Clinical Teams**: Asthma, HIV, Depression (fully integrated programs), Cancer, Pediatric Preventive Care, Prevention of Obesity in Children (ages 0-3)

- **Non-Clinical Teams**: Materials Management and Cycle Time

- **Program Development Teams**: Geriatric Clinic, Canyon Ranch Life Enhancement Program at UHP, Adolescent Pregnancy Prevention, and HUNTS POINT HOPE

- UHP conducts PI Training for Outside Organizations
Our Quality Improvement Journey Brought Us To...

- National Recognition
- Recipient of the Nicholas E. Davies Award
- Recipient of the Environmental Protection Agency National Exemplary Award for our Asthma Management Program
- NCQA Level 3 Certification Patient Centered Medical Home
- Named as a top performing health center by HRSA for ability to use data for quality improvement
- Learning Center
- Health Education Department
- Telephone Case managers
- Institute for the Advancement of Community Health
- Transformation of our Organization
Learning Points

- The team learned that Primary Care Providers can successfully treat uncomplicated depression in a primary care setting with the support of training, consultation, and an assigned case manager.

- The team learned that early intervention with depressed patients with provision of early intensive support is beneficial in attaining patient compliance with medication/treatment and in improving patients depression.
Looking Ahead

- Continue spreading Best Practices from Depression Program to Adolescent Behavioral Health Screening
- In Collaboration with Columbia University and Clinical Directors Network piloted Teen Screen
- Train Adolescent Clinic case manager on depression screening and follow-up process
- New Care Coordination Unit
Challenges

- Continuing to Increase Screening Levels
- Systematic Training of PCP’s upon Hire
- Supporting distant sites and assuring quality of depression program services at all sites
- Maximizing the Impact of Case Conferences
- Addressing patients who are not getting better
SOURCES:

- **NYC Community Health Profile for Mott Haven/Hunts Point:**

- **To learn more about BPHC health disparities collaboratives:**
  - [www.healthdisparities.net](http://www.healthdisparities.net)
Contact Information:

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Thank You!